MEDPAC Medicare Payment Advisory Commission

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Centers for Medicare and Medicaid Services
7500 Security Blvd., Building S3-0201
Baltimore, MD 21244-1850

RE: Draft revisions to the Minimum Data Set 3.0

Dear Ms. Lambowitz and Mr. Dudley:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed revisions to the Minimum Data Set (MDS), the patient assessment tool for nursing homes and skilled nursing facilities (SNF). We appreciate your staff's ongoing efforts to administer and improve the payment system for skilled nursing facilities, particularly given the agency's competing demands.

The draft revisions to the MDS 3.0 make many valuable changes to the patient assessment tool. The tool includes questions that directly ask residents about their pain, quality of life, and cognition, which are often underreported by staff and family members. Sections that the Commission previously identified as problematic—those assessing a patient's delirium, pressure ulcers, and pain—were revised to include more valid measures. The draft MDS 3.0 also uses language and questions from other assessment tools (such as the National Pressure Ulcer Advisory Panel's Pressure Ulcer Scale for Healing tool and the Confusion Assessment Method to describe delirium) that should make the information more consistent across settings. The revised draft also reportedly takes less time to administer, leaving caregivers more time to provide care to patients.

Although the draft MDS 3.0 offers many improvements over the MDS 2.0, we would like to raise two concerns with the January 15, 2008 version. The first issue centers on the look-back period included in Section O of the tool. This section records special treatments and procedures (such as intravenous medications) provided during the past 14 days (hence the term "look-back.") Because the patient's first assessment must be conducted on or about day five of the SNF stay, the assessment period can extend back to include services furnished during the preceding hospital stay. Yet, without accurate information

about services provided by the SNF, it is difficult to evaluate SNF service use and the value of Medicare's SNF purchases.

The July 2007 draft version of the MDS 3.0 appeared to have corrected this look-back problem. The Section O questions had been revised to ask about services furnished during the past 5 days or since admission if less than 5 days. This wording would have prevented the recording of hospital services in this section. However, the January 2008 version reverted back to using the problematic 14-day look-back period. We do not understand why the corrected questions were not retained in the January 2008 version. The longer look-back period extending back into the hospital stay will continue to make it impossible to distinguish between services furnished by the SNF and the hospital. We believe that the January revisions are wrong and urge CMS to correct the MDS 3.0 to separately record only services furnished by the SNF.

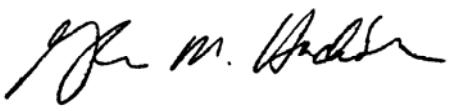
The 14-day look-back period may also have significant adverse payment implications for the program. The SNF prospective payment system relies on the services recorded in Section O to categorize patients into the case-mix groups. In the current and proposed MDS questions, services provided by a hospital can qualify days for higher-paying RUGs in a SNF, even if the SNF did not provide the service or incur the associated costs. As a result, Medicare can make higher payments to SNFs for services that were furnished by a hospital and already paid for by the hospital PPS.

A second area of concern is timing of the assessments. The Commission has repeatedly recommended that patient assessments be conducted at discharge from the SNF for all beneficiaries so that changes in patient conditions may be measured. Unfortunately, many beneficiaries are also not assessed close to admission. In 2003, only 4 percent of beneficiaries were assessed within 3 days of admission. Because assessments are conducted later in patient stays, changes in patient conditions are not accurately captured. Some patients may improve between admission and when the assessment is conducted, and this improvement is not recorded. Other patients' conditions may deteriorate between admission and assessment, and their reduced functioning will likewise be underreported.

The lack of assessments conducted at discharge and the timing of the admission assessments make it impossible to accurately measure changes in patient condition, tie payments to outcomes, and to assess the value of Medicare's purchases. If Medicare adopts pay-for-performance payments, the timing of when assessments are conducted will be key to properly rewarding and penalizing providers based on the changes in outcomes their patients achieved. As discussed in MedPAC's March 2006 recommendation, the providers' administrative efforts associated with the additional discharge assessment could be minimized with a shortened discharge MDS. This shortened assessment would need to include only select quality and pay-for-performance measures.

If you have any questions or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



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